GASTROSTOMY; ESTABLISHMENT OF A GASTRIC FISTULA, IN A CASE OF STRICTURE OF THE ŒSOPHAGUS.

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THE following case is worthy of record; for although the patient died in a fortnight of inanition, the operation itself was performed with success, the patient recovered from the effects of it, the wound healed, and a perfect gastric fistula was established.

The stomach, from long disuse, seemed to have lost much of its digestive and absorbent powers, so that the fluid nourishment which was introduced and retained failed to strengthen the patient. Whether an earlier resort to the operation might have enabled the man to live longer is difficult to say. But the case is another illustration of the fact that an opening can be made with safety into the stomach through the abominal walls.

Wm. B——, aged sixty, a porter, was admitted into Ward III. of the Western Infirmary on Sept. 10th, 1880, complaining of symptoms pointing to obstruction of the œsophagus. His family and personal history, apart from the present illness, are remarkably good. The symptoms above alluded to began in the month of February, 1880, with difficulty in the swallowing of solid food. Gradually this difficulty increased till, in the month of June, he was unable to swallow such substances as oatmeal porridge. For some time after this his diet consisted chiefly of porridge made with pea-meal. Soon, however, nothing but liquids could pass, and his diet was chiefly milk and beef-tea. On admission not even fluids could be swallowed, any attempt in that direction being followed by their regurgitation in a few minutes, or sometimes less, in a frothy condition. During all these months he had been getting steadily thinner, and on admission was very considerably emaciated. At no time was pain or dyspnœa a feature of the case; indeed, apart from the inability to swallow, he made no complaint but of weakness. Dr. Buchanan failed to pass a probang and œsophageal bougie, both of which stuck about half-way down the œsophagus.

No exact weight of patient was taken on admission, but it was evident that, notwithstanding the continued use of nutrient enemata, he was rapidly emaciating. These enemata were commenced on Sept. 20th. His weight on Oct. 16th was 7 st. 5 lb.; on Oct. 18th, 7 st. 2¾ lb. The emaciation continuing, Dr. Buchanan decided to operate, and on Oct. 27th gastrostomy was performed.

The operation.—An incision one and a half inches in length was made across the linea semilunaris, about an inch below and parallel to the eighth left costal cartilage. The tissues were divided down to the peritoneum and the cavity of the abdomen opened. The transverse colon was now exposed to view at the lower part of the wound. On the introduction of a pair of forceps in search of the stomach, the anterior wall of that organ was seen on withdrawing the instrument to have been grasped, and the gastro-epiploica artery on the greater curvature, two inches below the part, was seen to be held up. Through the part of the stomach wall thus brought to the opening two acupressure needles were thrust at a distance of one and a half inches apart, and, having been passed through the organ, were again thrust through the wall, and the ends made to rest on opposite sides of the wound. The stomach was now carefully stitched by ten carbolised silk sutures to the edges of the wound, and an incision about an inch in length made through the wall of

the organ, between the rows of stitches, with a pair of scissors. A smaller transverse incision was now made, and the resulting corners secured to the lips of the wound in the abdominal wall by stitches. The operation, which had been performed under the spray, now being completed, a large acupressure needle was pushed through a long indiarubber tube, about three inches from one end. This end was then introduced into the stomach, while the ends of the needle rested on the thoracic and abdominal walls. The tube was fixed in this position by lateral strings. The long end of the tube was bent downwards and the wound dressed with antiseptic precautions, drainage being secured by the open tube leading from the stomach. During the three days immediately following the operation the tube was used for drainage purposes, and a small quantity of brownish bilious fluid was collected.

No symptoms due to the operation can be said to have followed, unless perhaps a slight rise of temperature. The maximum temperature did not, however, now exceed 100° F. There was no pain, and no tympanites or other symptom of local or general peritonitis. For a day or two after the operation he was fed entirely by enemata of beef-tea and brandy (usually four or five in the twenty-four hours). On the 30th of October (the fourth day), previous to which the wound had been dressed on antiseptic principles, the dressings were taken off, and the drainage function of the tube changed into a nutritive one, half an ounce of milk and a drachm of brandy being introduced into the stomach. This was continued every two hours during this and the following day, after which the amount introduced was increased gradually, while the intervals of digestion were lengthened till on the 4th of November twelve to fifteen ounces of brandy and milk were introduced in four or five meals during the twenty-four hours.

On the 6th the tube was taken out permanently, and the mouth in the stomach closed by a pad of boracic lint, kept in position by two or three strips of sticking-plaster, the whole being removed when anything was introduced into the stomach by a syringe. On the same day twenty-six ounces of brandy and milk were introduced, and on the two succeeding days this was replaced in part by beef-tea, peptonised fluids, &c.

During all this time, although no untoward symptom had occurred, it was evident that emaciation was progressing in spite of the continued enemata and the feeding by the stomach. The sensations of the patient varied from day to day, but on the whole tended to those of slowly increasing weakness. Occasionally he wandered a little at night; sometimes he was morose, complaining, and easily annoyed, sometimes happy and hopeful in his expressions. On the 7th it became evident that he was losing strength quickly, and rapidly emaciating; and on the 8th of November, the thirteenth day from the date of operation, he died of asthenia, having been sensible to within an hour of his death.

The edges of the wound in the abdominal wall were united to the opening in the stomach within a few days of the operation, so that on removing and replacing the tube there was no tendency to separation of the edges, except at the inner angle, where there was a small slough of the subcutaneous cellular tissue. But this did not extend into the abdomen, the peritoneal surfaces of the stomach and abdominal walls having become adherent very early.

In a post-mortem examination it was found that there was a small oval tumour encircling the œsophagus about two inches and a half above the cardiac orifice of the stomach. The œsophagus passed through the centre of this swelling and was contracted for an inch of its length, so that a probe was with difficulty passed through it, even after the partial softening of the mucous membrane, which occurs soon after death. The upper orifice of this structure was plugged with a grape seed, of which the smaller end was downwards, so that it was fixed like a stopper in a decanter. The tumour was tough and firm, and its intimate structure was that of epithelial cancer.

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